DOCUMENT RESUME

ED 198 671 EC 131 797

TITLE Residential Services Position Paper.
INSTITUTION Pennsylvania State Dept. of Public Welfare, Harrisburg. Office of Mental Retardation.
PUB DATE Feb 80
NOTE 41p.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Group Homes; *Mental Retardation; *Normalization (Handicapped); *Residential Institutions; *State Programs; *Trend Analysis
IDENTIFIERS *Pennsylvania

ABSTRACT

The document states the future direction of the Pennsylvania Office of Mental Retardation in planning and policy development for residential programs. Section I provides an overview, traces the history of residential services in Pennsylvania, and describes the residential system in Pennsylvania as of June, 1978. Section II outlines a continuum of services (from independent living to institutional living) and considers anticipated and desired trends in residential program development. Consideration is given to independent living; family care homes; community living arrangements; interim care facilities; private licensed facilities; and state centers, mental retardation units, and contracted facilities. A final section offers recommendations for future action in the following areas: changes in law, regulations, and funding patterns; needed planning initiatives; program development strategies; improved program accountability; increased staff development capability; and provision of community education. (SBH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL RETARDATION

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

ED198671

RESIDENTIAL SERVICES POSITION PAPER

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Michael W
Bennett

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC131797

OFFICE OF MENTAL RETARDATION

DEPARTMENT OF PUBLIC WELFARE

COMMONWEALTH OF PENNSYLVANIA

RESIDENTIAL SERVICES POSITION PAPER

February 15, 1980

Jennifer L. Howse, Ph.D.
Deputy Secretary
Office of Mental Retardation

Helen B. O'Bannon
Secretary
DEPARTMENT OF PUBLIC WELFARE

TABLE OF CONTENTS

		Page
I.	INTRODUCTION	1
	A. Overview	1
	B. Historical Perspective	4
	C. Residential System - June, 1978	6
II.	PROJECTED RESIDENTIAL SERVICES	11
	A. Continuum of Services	11
	B. Residential Trends	15
III.	RECOMMENDATIONS FOR FUTURE ACTION	20
	A. Changes in Law, Regulations and Funding Patterns	20
	B. Needed Planning Initiatives	22
	C. Program Development Strategies	24
	D. Improved Program Accountability	30
	E. Increased Staff Development Capability	31
	F. Providing Community Education	33
	G. Conclusions	33

TABLES AND FIGURES

Figure A - Theoretical Continuum of Residential Service Models	3
Table I - Summary of Client Characteristics for Each Residential Program Category	7
Figure B - Residential Services Continuum	12
Table II - Residential Services Models	16

I. INTRODUCTION

A. Overview

This paper is a statement of the future direction of the Office of Mental Retardation (OMR) in planning and policy development for residential programs.

The OMR position on residential services is predicated upon adherence to the developmental model. The model presumes that individual clients are capable of acquiring more complex and independent behaviors. Therefore, the system of residential services should assure opportunities for mentally retarded persons to progress along a continuum of services ranging from larger to smaller settings, group to individual residences, dependent to independent living, and isolated to integrated living within the community. The residential settings along the continuum should provide mentally retarded persons opportunities to live as independently as possible in the most individually appropriate setting.

The concepts of restrictiveness and normalization are also incorporated into the models of residential services presented in this paper. Residential service models may be fixed upon a continuum ranging from least to most restrictive. Restrictiveness refers to the properties of the environment that impact upon individual choice and potential for growth. Restrictiveness varies as a function of:

- freedom of movement and ability to participate in the community
- potential for effective habilitation and treatment.

By applying these criteria, large, isolated, self-contained facilities affording minimal individualized programming are likely to be most restrictive while small settings, integrated into local communities, and offering individual prescriptive programs, appear on the least restrictive end of the continuum.

Residential service models can also be characterized by the extent to which they comply with the principles of normalization. Bengt Nirje described the principle of normalization as "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society." Residential service models vary on this dimension according to the extent to which they:

- o incorporate normal routines of daily living
- o are structurally and architecturally similar to other residences in the same community
- o allow individual privacy and expression in accord with cultural norms.

The most appropriate residential service models successfully combine the characteristics of least restrictiveness and normalization.

Residential models can be ordered sequentially from most to least preferred based upon reference to this conceptual system, as illustrated in Figure A.

This paper addresses the future direction of residential services in Pennsylvania within the context of the conceptual system outlined above. Part B of the Introduction presents an

FIGURE A: CONTINUUM OF RESIDENTIAL SERVICE MODELS

historical perspective of residential services in the Commonwealth from the 1960's to the present. Part C reviews the current residential system using data describing the characteristics of the clients and residential settings in 1978. Section II describes OMR's projected residential services within a specified continuum and outlines projected residential census trends. Section III presents the major administrative initiatives OMR will undertake to achieve needed changes in the current residential system.

B. Historical Perspective

Residential services in Pennsylvania have evolved over the past 15 years in response to statute, executive policy, and litigation.

Until 1966, the Commonwealth did not have a statutory basis to mandate the development of community services for its mentally retarded citizens. The primary source of services available in the Commonwealth were the large, remote, state-operated residential settings which served a total of 13,470 clients. With the passage of the Mental Health and Mental Retardation Act of 1966, local authorities (County Commissioners) were required to establish a community service system for both mentally retarded and mentally ill persons. The Act specifically required local authorities to provide a minimum of nine mandated services. However, many of these mandated services were mental health oriented and had little direct impact upon the needs of mentally retarded persons in the early stages of implementation of the Act.

By 1970, the minimum requirements of the MH/MR Act were being implemented by each of the 41 MH/MR Administrative Units* that were formed under the Act.

The establishment of a community system began to reduce the demand for state institutional services. However, the volume of resources was not sufficient to meet the community residential needs of the mentally retarded. The Act prescribed the provision of a single residential service for mentally retarded persons as one of the nine mandated services in the community MH/MR program. This mandate, referred to as "interim care", was intended to provide temporary residence to persons "awaiting admission to a state-operated facility." The "interim care" provision of the Act has provided funding for the placement of persons in private residential facilities licensed by DPW.

In 1972, the Commonwealth recognized the need to develop smaller homelike community residential services as an alternative to public and private institutions and established the Community Living Arrangements (CLA) program.

Litigation provided another major impetus to the evolution of community-based residential services for mentally retarded persons in Pennsylvania. The most significant changes have resulted from:

1. The Right to Education Consent Agreement (Pennsylvania, 1972)

   The Right to Education Consent Agreement requires that every mentally retarded child in Pennsylvania have access to a free public program of education. This requirement has reduced the need for parents to seek residential placements for children in order to obtain education and habilitation,

* There are currently 43 Administrative Units.

thus reducing the need for admission of mentally retarded children to residential programs. The impact has been most dramatically realized in the reduction of children's admissions to state centers from 1972 to 1980.

2. The Pennhurst Decision (Pennsylvania, 1977)

This decision affirmed that mentally retarded individuals have a right to treatment in the least restrictive environment. The implication of this order is that residential services should be provided in small settings located in the community. The implementation of this order will lead to a reduction in the number of residents at Pennhurst and the development of an increased number of small residences in communities.

In summary, the movement of over 3,600 clients out of state centers and the reduced requests for admission since the 1966 Act are in large measure due to the development of community residential settings. To accommodate the growing demands for decreasing the population of state centers based on the need to comply with federal standards by July 1982, and to keep pace with the residential needs of community clients, a significant number of additional community settings will need to be developed.

C. Residential System - June, 1978

Description of Client and Setting Characteristics

During 1978, the first comprehensive client survey was undertaken by OMR. Table I presents a summary of client characteristics by category of residential setting operating in the Commonwealth on June 30, 1978. These data are still representative of the characteristics of each currently-operating setting. Residential setting categories included in Table I are:

1. State Centers - These include 12 state-operated settings ranging in size from 191 to 1,492 beds. They serve

RESIDENTIAL PROGRAM CATEGORY	NUMBER OF CLIENTS (% of total)	NUMBER OF SETTINGS (% of total)	FUNCTIONAL LEVEL (% within residential category)					CLIENT AGE (% within residential category)			OTHER (% within residential category)	
			Non-MR	Mild	Moderate	Severe	Profound	0-21	22-64	65+	Non-Ambulatory	Deaf
STATE CENTERS	7674 (51%)	12 (1%)	76 (1%)	614 (8%)	1458 (19%)	2379 (31%)	3147 (41%)	1381 (18%)	6062 (79%)	231 (3%)	1535 (20%)	537 (7%)
MR UNITS	471 (3%)	7 (.7%)	24 (5%)	150 (32%)	212 (45%)	85 (18%)	0	5 (1%)	433 (92%)	33 (7%)	9 (2%)	18 (4%)
CONTRACTED FACILITIES	777 (5%)	4 (.4%)	8 (1%)	23 (3%)	124 (16%)	389 (50%)	233 (30%)	117 (15%)	583 (75%)	77 (10%)	311 (40%)	62 (8%)
PRIVATE ICF/MR	160 (1%)	1 (.1%)	DATA NOT AVAILABLE					NOT AVAILABLE			NOT AVAILABLE	
PLF	3223 (2%)	46 (5%)	64 (2%)	452 (14%)	677 (21%)	612 (19%)	1418 (44%)	2256 (70%)	935 (29%)	32 (1%)	548 (17%)	161 (5%)
CLA	2755 (18%)	925 (93%)	413 (15%)	1019 (37%)	937 (34%)	303 (11%)	83 (3%)	689 (25%)	2038 (74%)	28 (1%)	28 (1%)	83 (3%)
TOTAL	15060 (100%)	995 (100%)										

1. As of June 30, 1978

TABLE I: SUMMARY OF CLIENT CHARACTERISTICS FOR EACH RESIDENTIAL PROGRAM CATEGORY[1]

predominantly (79%) adults, most of whom (70+%) are severely or profoundly retarded. Program services are generally provided in-house and focus on acquisition of daily living and prevocational skills. The centers participate in the federal Title XIX ICF/MR program, and draw significant federal reimbursement.

2. MR Units - These include seven state-operated settings ranging in size from 50 to 150 beds. They serve adults, most of whom (77%) are mildly or moderately retarded. Program emphasis is upon maintenance of adaptive behavior and the acquisition of vocational skills. The MR Units also participate in the federal ICF/MR program.

3. Contracted Facilities - These include four facilities operated by private providers, ranging in size from 130 to 180 beds. Most residents (75%) are adults who are primarily (80%) severely or profoundly retarded. A large percentage (40%) of these residents are non-ambulatory. Program services are delivered exclusively in-house with an emphasis upon acquisition of basic self-help skills. The facilities are state funded with reimbursement from Title XIX.

4. Private ICF/MR (1978 data) - This refers to a single 160-bed facility serving children. It is operated by a private provider and has been licensed and certified for participation in the Title XIX program.

5. Private Licensed Facilities (PLF's) - These are 46 residential

settings operated by private providers and licensed by DPW. They range in size from 14 to 400 beds and serve predominantly (70%) children, most of whom (63%) are severely or profoundly retarded. Program services rely heavily upon the Intermediate Units for mandated education. Funding is provided through 100% state contribution for interim care provided in individuals on the waiting lists for state centers. After care, for individuals leaving state centers, is funded 90% by the state and 10% by the local county.

6. Community Living Arrangements (CLA's) - This is a statewide residential program operated by counties with 100% funding provided by the state. Over 925 settings serve 2,755 residents (1978 data). The majority of residents are adults (75%) and most (71%) are mildly or moderately retarded. Program services emphasize vocational placement for adults. Day programs are generally provided outside the home while in-house programs emphasize refinement of daily living skills.

The facilities included in these six categories represent nearly all the sites in which residential services are provided to mentally retarded persons in Pennsylvania.

The data in Table I presents a number of salient facts:

- Residential services are provided to 15,060 persons in 995 different residential program settings; 51% of the clients receive residential program services in state centers.
- Residential categories with the largest percentage of severely and profoundly retarded clients are Contracted Facilities (80%), State Centers (72%), and PLF's (63%).

- Contracted Facilities, State Centers and PLF's also represent the residential categories with the highest percentage of non-ambulatory clients (40%, 20%, and 17% respectively) and clients who are blind or deaf (8%, 7%, and 5% respectively).

- CLA is the residential category with the largest percentage of clients who are either mildly retarded or not retarded (52%). Non-retarded clients were inappropriately institutionalized in state centers and moved to CLA's in transition to more appropriate settings such as independent living.

- PLF is the only residential category serving primarily children (70% of the residents are under 21). The second highest percentage of children in residence (25%) occurs in CLA's.

- While MR Units have the highest percentage of mildly and moderately retarded clients (82%, including persons not retarded), this population tends to be characterized by a greater incidence of behavioral problems.

II. PROJECTED RESIDENTIAL SERVICES

A. Continuum of Services

Figure B depicts a conceptual system of residential service models based upon the dimensions of restrictiveness and normalization. Specific residential models can each represent varying degrees of restrictiveness and compliance with the normalization principle. Further, residential service models may be ordered from least to most preferred depending upon the extent to which client needs are adequately satisfied and services are provided in the least restrictive, most normal manner. According to this scheme, the most preferred model for residential services for a given individual is represented by independent or family living. The least preferred model is represented by the institution. Supportive living covers the broadest range of restrictiveness from relatively non-restrictive to highly restrictive while maintaining the potential to adequately address normalization.

Description of Residential Service Models

1. Independent Living

This is the most preferred model for mild to moderately retarded adults. Adult mentally retarded persons served in the independent living model are most likely to be engaged in vocational training or competitive employment and receive needed services externally through generic service providers. Staff is not routinely provided in the residential setting itself, but would be accessible to clients if specific needs required staff presence.

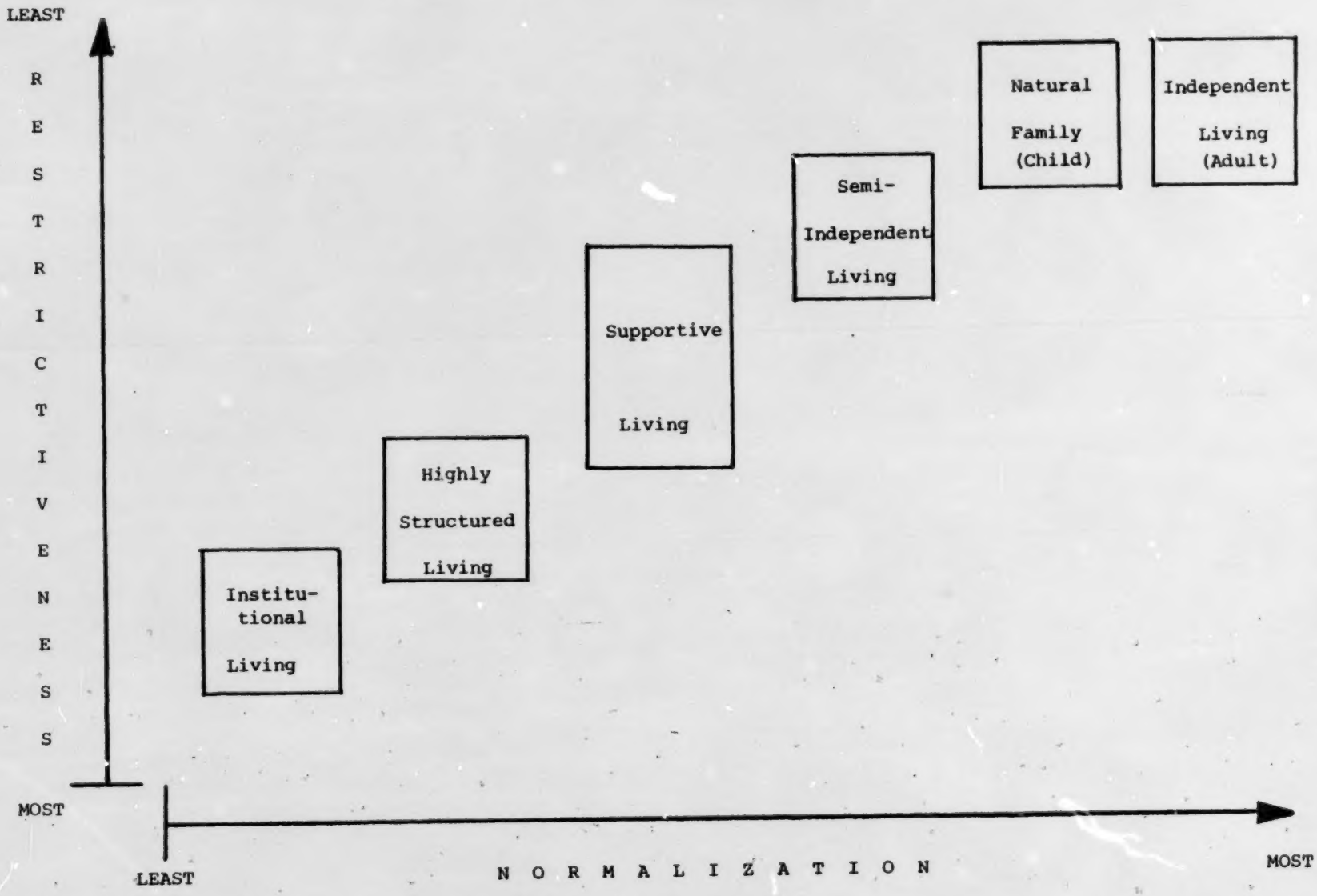

FIGURE B: RESIDENTIAL SERVICES CONTINUUM

2. Natural Home

The natural home is the preferred model for children at all levels of disability. Children residing in the natural home must be provided with programs of stimulation as well as medical/nursing support as needed. These services are to be provided external to the home as much as possible. Education is provided to children residing in the natural home in a public school setting. Staff is not routinely provided for children in their natural homes, but would be available to meet specific needs. In addition, this model emphasizes parent training to assure adequate support for maximum development.

3. Semi-Independent Living

Settings for semi-independent living serve adults who are mildly to severely mentally retarded. The settings include CLA minimal supervision programs and could include family care homes. Adults served in this model will often participate in programs provided external to the residential setting that focus upon the development of self-management and competitive work skills. Staffing is provided in the residential setting itself only at intervals as required by the individual's program to promote more independent living.

4. Supportive Living

Settings included in the supportive living model are ICF/MR's of 15 beds or fewer, Community Living Arrangements, and family care homes. Adults and children at all levels

of disability and medical complexity are served through this model. The emphasis of services is upon refinement of daily living skills. Adults often participate in external programs focusing on the development of work skills. Education is provided to children. Supervision is available by staff in this setting on a 24-hour basis, and staff, or the family care giver, is present whenever clients are in the home.

5. Highly-structured Living

This model is provided in the following settings: ICF/MR's of 15 beds or fewer, PLF's of 15 beds or fewer, and Community Living Arrangements. Clients served by this model include children and adults who are severely and profoundly retarded or any retarded individual who has specific behavioral and/or medical problems. Services are geared to assure the acquisition of activities of daily living and/or the modification of problem behaviors. Children are provided educational programs. Adults may participate in treatment-oriented day programs, day training of work skills or competitive employment. Program services are provided both internal and external to the setting. Twenty-four hour staffing for both program services and supervision of clients is provided.

6. Institutional Living

State centers, MR Units, contracted facilities, ICF/MR's of 16 beds or more, PLF's of 16 beds or more, are settings which exemplify the institutional model. Only adults who are severely or profoundly retarded and present medical and/or behavioral problems and adults who are mildly or moderately

retarded with severe behavioral or medical problems will be served by this model. Services are provided by institutional staff and focus on acquisition of daily living skills, pre-vocational skills and the modification of problem behaviors. Twenty-four hour supervision is provided with additional staff in the setting responsible for habilitative programming. Programs must be geared to short term intervention with a goal of reintegrating the individual into a community setting as rapidly as possible. Table II summarizes the residential service models described above.

B. Residential Trends

While complete data are not available for projecting future residential program enrollments, it is possible to identify the anticipated and desired trends in residential program development for the coming years based upon current client characteristics, OMR programmatic priorities, and funding realities.

1. Independent Living

It is the view of OMR that for most adults independent living provides the most preferred living arrangement. OMR's efforts will be geared toward providing a service system that can support independent living for mentally retarded persons so that it will become possible for all clients capable of independent living to reside in their own communities. It is anticipated that there will be very few placements of clients directly from state centers into independent living settings. A substantial number of placements into independent living settings will be

MODEL	TYPE OF SETTING	CLIENT CHARACTERISTICS[1] (Relate to levels of functioning, not IQ tests)	PROGRAM		
			Emphasis	Support Services Delivery Mode	Residential[2] Staffing
Independent Living	Own Home	Adults; Mildly to Moderately Retarded	Competitive Employment Retirement Vocational Activities	External Generic	None
Natural Home	Parent's Home Adoptive Parent's Home	Children; Mildly to Profoundly Retarded Medically Complex, Behavior Problem	Early Intervention Education/Stimulation Parent Training, As Need Medical/Nursing, Therapies, FRS Services	Primarily External Generic	None
Semi-Independent Living	CLA Minimal Supervision Family Care Homes	Adults; Mildly to Severely Retarded	Self Management Retirement Vocational Activities Competitive Employment	External Generic	As Required at Intervals
Supportive Living	ICF/MR 15 Bed or Less CLA 3 Bed or Less Foster Homes Family Care Homes	Adults or Children; Mildly to Profoundly Retarded Medically Complex	Refinement of Activities of Daily Living Skills Vocational Activities Competitive Employment Early Intervention Education (Children)	External Generic	24 Hours or Whenever Client(s) Present
Highly Structured Living	ICF/MR 15 Bed or Less PLF 15 Bed or Less CLA 3 Bed or Less	Adults or Children, Mildly to Profoundly Retarded, Problem Behaviors, Medically Complex	Acquisition of Activities of Daily Living Skills, Modify Problem Behaviors, Vocational Activities, Competitive Employment, Stimulation Education (Children)	Internal (Time Limited) External Generic (On-going)	24 Hours or Whenever Client(s) Present
Institutional Living	State Centers, MR Units, Contracted Facilities, ICF/MR 16 Beds or More, PLF 16 Beds or More	Adults; Severely and Profoundly Retarded; Mildly and Moderately Retarded, Problem Behavior, Medically Complex	Same as Highly Structured Living (May encompass all programs above)	Internal/ External Contracted	24 Hour

1. Physical handicaps (deafness, blindness, ambulation problems, etc.) can be accommodated in any model.

2. Staffing may vary as clients are prepared to move to the next model.

TABLE II

RESIDENTIAL SERVICES MODELS

adult clients currently residing in CLA's, especially the large number of non-retarded and mildly retarded clients residing in CLA's.

2. Family Care Homes

In order to further enhance the development of less restrictive residential settings, OMR will attempt to increase the opportunities for the placement of retarded clients in family care settings. These settings will be modeled after the existing foster care system operated through the Office of Children, Youth and Families. However, special training is to be provided to family care parents. As one alternative to new admissions to MR institutions, additional family care program settings will be aimed at increasing placements for children of all functional levels who cannot remain in their natural homes.

3. Community Living Arrangements (CLA's)

The CLA program will continue to be an important cornerstone for the provision of community residential services with the operation of three different types of programs.

CLA minimal supervision settings will be developed for clients preparing for eventual transfer to independent living settings. This setting intends to serve more highly skilled clients nearing placement in independent living settings and, as such, supervision may be provided at intervals as defined in the individual's program.

CLA supportive settings will be developed for children and adults transitioning from a more highly structured CLA setting. These clients, while approaching independent living skills,

require regular, 24-hour, supportive supervision.

The most highly structured CLA settings will continue to serve behaviorally and medically complex children and adults who have moved out of institutions or resided in the community. These programs will use both live-in and 24-hour shift staffing models to provide supportive supervision in a family-like setting.

4. ICF/MR's

Community ICF/MR settings with 15 beds or fewer (including multiple 3-bed clusters) need to be developed to serve the majority of the severely and profoundly retarded and/or multiply handicapped clients being deinstitutionalized and/or awaiting such programs in the community. This program will also serve mildly and moderately retarded persons with behavioral and/or medical problems. A comprehensive plan to develop 4 to 15 bed ICF/MR's will be prepared by OMR in conjunction with existing and prospective service providers and the counties.

5. Private Licensed Facilities (PLF's)

OMR supports the placement of children out of PLF's larger than 16 beds into smaller community settings and intends to develop incentives to assist the providers and counties in this effort. Therefore, the PLF's will be called upon to be serving a different population. The resultant PLF vacancies will be used for adults from state centers and the community who are generally characterized as severely or

profoundly retarded with severe behavioral and/or health management problems. Efforts will be made by DPW to limit the placement of out-of-state children in PLF's and to return out-of-state children to their own states for services.

6. State Centers, MR Units, Contracted Facilities

In order to meet federal ICF/MR mandates and to achieve a clear programmatic emphasis on the deinstitutionalization of MR services, the client census in state centers and MR Units must be significantly decreased. Children will be the highest priority for community placement and it will be recommended that institutional admissions be closed on a selective basis. OMR intends to refocus the long-term residential care role of these programs to one of community resources providing time-limited specialized services.

7. Other Issues

There are several special populations needing residential services which will require special residential program planning. These groups include:

- Mentally retarded persons who are legal offenders who may or may not have been adjudicated competent and have been unable to date to receive appropriate services. There are 13 of these clients at Farview State Hospital and an estimated 30 to 50 others known statewide.
- Approximately 360 mentally retarded residents of state psychiatric centers.
- Persons having dual diagnoses of mental retardation and emotional disturbance.
- Elderly mentally retarded persons.
- Severely medically involved infants primarily being served now in Private Licensed Facilities.

III. RECOMMENDATIONS FOR FUTURE ACTION

The challenge set forth by this position paper is to develop the full continuum of services outlined in Section II, to successfully move the mentally retarded citizens of the Commonwealth into these services, and to satisfactorily maintain quality. Simply put, a series of actions must occur through a combined partnership of government, service providers, parents, and consumers.

The Office of Mental Retardation proposes that future action be directed toward six areas:

A. Changes in State Law, Regulation and Funding Patterns

B. Needed Planning Initiatives

C. Program Development Strategy

D. Improved Program Accountability

E. Increased Staff Development Capability

F. Providing Community Education

The remainder of this paper will set forth suggested approaches to each of these areas.

A. Changes in Law, Regulation and Funding Patterns

Legislative modifications and/or changes in DPW regulations are needed in order to provide a clearer statutory basis for the provision of a comprehensive system of residential services for mentally retarded/developmentally disabled persons. The current statutory basis for the provision of mental retardation services, the 1966 MH/MR Act, should be modified to accomplish the following objectives:

- o Mandated services should be integrated to include the

following:

1. Information and referral
2. Diagnosis and evaluation
3. Case management
4. Family training and home services
5. In-home therapy
6. Early intervention
7. Prevention
8. Respite care
9. Behavior management services
10. Residential services
11. Habilitation, day training, job placement
12 Recreation, social and leisure activities

- Under the provisions of the 1966 MH/MR Act, placement in a PLF is funded with 100% state funds only when a client is on a waiting list for admission to a state center. Counties are required to pay 10% of the cost of placement of a person in a PLF under any other circumstance, including movement from a state center or MR Unit to a PLF. In order to insure the availability of beds in PLF's for the placement of former state center residents, allowance for 100% state funding (analogous to "interim care") should be provided by amending the existing Act. Allowing for 100% state funding for all county contracted PLF placements is essential for reducing the client census in state centers. Further, counties have a disincentive to moving clients out of state centers into PLF's because they must pick up 10% of day and support service costs. This should be examined in light of the increased need to move state center clients into community based settings

At present, there are three proposed legislative bills under review in the Pennsylvania House of Representatives modifying local zoning laws which have impeded the development of community residential programs. The proposed zoning legislation, which will require considerable support for passage, calls for municipalities to track and monitor the locations of all community residential programs in their communities, allowing municipalities to review the locations of proposed community residential programs in light of existing programs in particular geographic areas.

Such legislation could be very valuable in fostering local involvement and support in site selection.

To assist in this tracking process, OMR will propose to develop and coordinate systems for mapping, updating, and disseminating site information to counties and local municipalities. These data could then be used to direct the selection of program sites and to focus the location of neighborhood community education activities.

B. Needed Planning Initiatives

Modification of the current county/state planning and budget allocation process will be required to support federally mandated reductions in the existing state center population, and to accommodate anticipated program growth especially in community based ICF/MR's.

1. County Plans

The existing process, which integrates the participation of counties, providers, OMR, and DPW, allows for the timely provision of data in accordance with the Executive budget cycle, but does not typically provide counties with final allocation letters early enough in the fiscal year to assure sufficient lead time for new service development. Every effort will be made by DPW to expedite the issuance of final allocation letters. County governments will need to cooperate by providing prior fiscal year expenditure reports in a timely fashion and by initiating concrete planning based on targets established 18 months in advance of the plan year, and modifying plans based on budget stages as follows:

o Deinstitutionalization goals are established by OMR and provided to state centers and counties as part of the plan and budget estimate instructions.	- 19 months prior to Plan Year
o State centers and counties submit plan and budget estimate to OMR based on deinstitutionalization goals.	- 12 months prior to Plan Year
o DPW submits budget request to the Governor's office incorporating state center and county plan data.	- 9 months prior to Plan Year
o Governor submits budget to General Assembly based upon input from DPW.	- 5 months prior to Plan Year
o Counties and state centers refine plans based upon levels of funding contained in the Governor's budget request.	- 4 months prior to Plan Year
o Counties issue RFP's for development of community residential programs contained in refined plans.	- 2 months prior to Plan Year

Once the Governor's office develops a final budget, OMR's deinstitutionalization goals can be refined based upon expected levels of funding. These refinements can then be communicated to the counties who must refine and develop operational plans for the expansion of community programs based upon anticipated funding. Once these operational plans are reviewed and approved by OMR, counties may issue requests for proposals prior to the start of the planning year. After the appropriations are passed and allocations are made, providers and sites will be identified, and the process of starting up new programs can be implemented.

2. OMR Facility Five Year Plan

The first Five Year Plan for state centers and MR Units will be completed by April 1980. The plan outlines the approach to be taken by OMR to bring its centers and units into compliance with the

requirements of the federal ICF/MR standards, thereby maintaining 55% federal financial participation in these institutional programs. The pivotal point in the state's compliance strategy is the reduction of client census by 900 by July 1982. This reduction is to be accomplished primarily through community placement. Following completion of the Five Year Plan, planning sessions will need to occur between OMR regional offices and county staff to ensure that county plans adequately reflect needed placement development.

C. Program Development Strategies

1. Natural, Adoptive, and Family Care Incentives

Of all the residential alternatives available to mentally retarded persons, the Commonwealth has failed to adequately emphasize the most obvious resource -- the person's "natural" home, and similar situations provided by family care and adoptive homes. Existing provisions for subsidy to adoptive and family care parents must be systematically assessed, and new program elements developed as needed. A similar effort to provide resources to natural parents in order to insure the maintenance and adjustment of mentally retarded persons with their families should be considered. Because of increasing emphasis on placement in a natural or adoptive home, DPW intends to examine the issue of parental fiscal liability for services.

2. Proposed ICF/MR Development

OMR will develop a plan for the development of new ICF/MR settings for 4 to 15 persons. This plan will outline the responsibilities of OMR, Department of Health, and the Office of Medical Assistance. OMR will negotiate appropriate interagency agreements delineating

responsibility for surveying, rate-setting, client eligibility, Independent Professional Review (IPR), Utilization Review (UR) and monitoring. This plan will require approval by DPW and HEW Region III.

The proposed ICF/MR development will encompass at least six possible service models providing a range of clinical, direct-care, and support services based on client needs. These models will be designed to provide the necessary flexibility to supply the specific services required by each client's handicapping conditions. The clinical services rendered may be diagnostic or therapeutic as may be required by the client's individual habilitation plan.

These models are as follows:

- In-house day programming providing an emphasis on a behavior modification program serving children or adults who are dual diagnosis (mentally retarded & emotionally disturbed) or extreme behavior management problems. Clinical intervention will provide a full day of active clinical programming for each client with a goal of phasing each person into an appropriate community day program as rapidly as possible.

- In-house programming providing an emphasis on the acquisition of activities of daily living skills serving children or adults. Clinical intervention will provide a full day of active clinical programming for each client with a goal of phasing each person into an appropriate community day program as rapidly as possible.

- Outside day programming and an internal emphasis on the acquisition of activities of daily living for medically complex and/or behavior problem children. Clinical services supplement active treatment programming occurring outside the facility

- Outside day programming and an internal emphasis on the acquisition of activities of daily living for medically complex and/or behavior problem adults. Clinical services supplement active treatment programming occurring outside the facility.

- Outside day programming and an internal emphasis on the

refinement of activities of daily living skills for children. Clinical services will supplement active programming occurring outside the facility.

- Outside day programming and an internal emphasis on the refinement of activities of daily living skills for adults. Clinical services will supplement active programming occurring outside the facility.

These proposed models should provide a sufficient level of service to accommodate the more complex needs of clients moving from state centers and from the community.

3. Day Programs and Educational Services

In order to provide an adequate level of day programming for adults with extreme skills deficits, a comprehensive system of day treatment and training programs must be developed. Day treatment programs are designed for developmentally disabled individuals who have severe habilitation or health related needs and who require active and continuous treatment and supervision 24 hours a day, but who can benefit from receiving services in more than one setting. Day treatment is the most intense level of day programming available, and as such, represents the treatment of choice for individuals who do not have the skills necessary to function in a day training environment. Core, routine, and special services are provided to each client in accordance with the client's individual program plan.

OMR will undertake initiatives the next fiscal year to design day treatment programs which will qualify for federal Title XIX funding, and to assess the level of need for such programs in the Commonwealth. It is estimated that the majority of adults leaving state centers will require this level of day program, at least initially.

For adults already in vocational training programs, OMR will seek the means to ensure that capable individuals are placed in programs developed to result in competitive employment. Emphasis in vocational rehabilitation programs will be upon short term training and increased opportunities in the community for gainful employment.

OMR must use new initiatives to assure a meaningful and smooth transition for individuals moving from public school special education to adult programs and/or employment.

In contrast to OMR's strong emphasis on the physical and social integration of the residential services, most severely and profoundly retarded children residing in the community and served by the Intermediate Unit System do not have much opportunity for social integration with their non-disabled peer group. Efforts must be made to encourage the development of more integrated public education.

4. Support Services

Support services must be adequately and effectively linked to residential services to assure comprehensive individual programs. Transportation, travel training, medical and dental services, therapies, homemaker services and respite care are among the array of services that must be conveniently located and adequately funded. To the greatest extent possible, services should be provided through generic community resources and a "natural social network" including parents, friends, social groups, and local recreational facilities.

The communities of physicians, dentists and therapists must actively support and foster the availability of high quality services for the retarded persons residing in their communities. Efforts to

familiarize local practitioners with the needs of the retarded should be systematically approached by professional organizations. Without the commitment of the generic practitioners to integrate services, OMR's goal of normalizing services will not be achieved.

Transportation systems will have to be extended to ensure access to community resources. Vehicles for recreational and other individual activities must be made available by increasing county contracts with vendors and/or supplementing residential service budgets for leasing or acquiring vehicles.

Homemaker services are crucial to maintaining an individual in his natural home by providing relief and supplementation to the family. Present funding is inadequate to provide the volume of homemaker services required to meet the needs of families requesting relief. Additional money for homemakers is necessary if the services are to be adequately expanded to support OMR's proposed placement effort.

Additional services for persons living with their families as provided by Family Resources Services are: respite care, family training, recreation, in-home therapies, transportation, and family aid for sitters. The availability of these services to clients residing in community settings other than their natural homes is provided through agency contracts with the counties or through generic community services, where available. The provider agency's ability to access services in the community is dependent upon its availability within the community, and/or funding capability to either contract for or directly provide the needed service.

OMR will assist the counties in developing systems to gather and

analyze data in a timely manner. The county plans will continue to be the mechanism for targeting and emphasizing service areas.

5. Private Licensed Facilities (PLF's)

As previously stated in Section II, OMR intends to call upon the PLF's to significantly change their current program direction. With priority for children's services being directed towards smaller, more homelike, settings, the PLF's will be urged to gear up for an adult population. However, interested PLF providers will be encouraged to assist in the development of the small, community based ICF/MR's for children. Additionally, to maximize federal funding, PLF's will be scheduled for conversion to ICF/MR's by 1983; this conversion will help to insure the operation of quality programs through compliance with federally established standards for services.

Finally, the issue of out-of-state children residing in Pennsylvania PLF's is beginning to attract sufficient attention to become a public policy issue. Clearly, PLF providers will have an active role as the out-of-state policy takes shape.

6. The Future Role of State Centers

The role of state centers will be significantly redefined over the next five years. The general direction will be towards the provision of time limited specialized services, residential care for clients with extreme behavior problems, and clients with very complex medical needs. The centers will service only those clients from their specific catchment areas. The existing number of clients, staff and physical facilities will be reduced over time.

D. Improved Program Accountability

1. Case Management Services

Case managers provide the critical link between the client and the community service system. Case management services need to be refined to insure quality control and accountability on an individual basis. The county program is usually responsible for providing a case management system to perform several functions for all retarded clients living in the community. These functions include:

- o case finding
- o intake and referral
- o individual program planning
- o program coordination
- o case monitoring

There are currently no standards or guidelines to govern case management services. OMR plans to work with county MH/MR administration to develop over the next 12 months a case management position paper and based on the results of this effort, will determine if there is a need to promulgate regulations governing case management services.

2. Monitoring Community Residential Services

OMR is developing a system to monitor residential services. Ensuring quality control is the responsibility of the counties, regions and central office. A set of regulations governing the licensing of residential facilities will be promulgated by July 1980, fixing the role and responsibility of OMR to evaluate community residential settings and the provider agencies' requirements for continued operation.

OMR will also develop procedures for community residential

evaluations based on the regulations. Compliance with these regulations and a demonstrated system of correction for deficiencies will become the basis for determining a provider agency's future program development opportunities.

Additionally, the ICF/MR Survey, Utilization Review, and Independent Professional Review will supplement OMR's efforts to guarantee quality control systems.

E. Increased Staff Development Capability

The ability to expand residential services in Pennsylvania, while at the same time maintaining a high level of program quality, depends upon the ability to train currently-employed staff and develop a qualified pool of new personnel. Of particular concern is the present lack of skilled staff available to work with clients who are severely or profoundly retarded and who also exhibit significant behavioral/medical problems.

The Office of Mental Retardation has initiated a systematic process for the development of a comprehensive staff training plan. Once developed, this plan will guide the development and deployment of training resources both at the state and local levels. It will also serve as a basis for the identification of existing or additional resources which can be brought to bear on the training needs of the MR system. The training plan will address the specific needs of the community residential program in the context of the broader system of mental retardation services capitalizing upon existing resources and orchestrating mutually-beneficial relationships between various parts of the system. Specifically, an effort will be made to develop active

and ongoing relationships between state centers and county programs within the immediate proximity as well as supportive relationships between state-operated and funded educational facilities and community programs. The plan will be completed by July 1980.

Training activities will focus on insuring adequate preservice training for new staff entering community residential programs as well as intensive and graduated in-service training programs for currently employed staff. At the same time emphasis will be placed upon the development of training activities that will serve to retrain staff currently employed in community residential and institutional programs who serve a changing clientele.

As institutional populations are reduced, it will become increasingly important to plan for the orderly reduction of staff complements. In order to effect this orderly reduction, OMR will promote the recruitment of qualified institutional staff for community settings. The degree to which the institutional staff may be redeployed, however, is largely dependent upon staff deriving equivalent benefits from employment in the community as was afforded under state employment. Specifically, rates of salary and fringe benefits must be considered. Planning for satisfactory accommodation for the equitability of these areas will require the active participation of county governments, labor unions, DPW, the Legislature and the Governor's office. A task force should be formed by the Governor's Office to study alternative approaches to maximize portability potential and to minimize the economic effects of severance.

F. Providing Community Education

The attitude of community leaders, the general public, and the elected officials of the Commonwealth is of crucial importance to the continued development of community services. The development of a community-based residential system is a complex process which becomes even more difficult without active community support.

Unfortunately, financial resources for use in promoting public education and increasing community awareness are very limited, and any plans developed for public education must contend with the sparsity of fiscal support available.

Nevertheless, in order to assist the evolution of positive attitudes among the general public regarding community residential development, the Office of Mental Retardation will extend its assistance and resources in partnership with Pennsylvania Association for Retarded Citizens (PARC) and other service providers and advocates to support a statewide public education effort. This effort should focus on regional, county, and neighborhood levels to develop strategies to win support for local residential development.

G. Conclusions

The residential trends outlined in this paper can be modified over time based on experience. However, it is OMR's intent to proceed in the direction set forth, and to work with county government, service providers, clients, parents and advocates to bring about needed changes in Pennsylvania's system of residential services.